PD-ABX-351

Annex 7

USAID/EGYPT POPULATION AND HEALTH SUSTAINABILITY AND TRANSITION PLAN: 2002 - 2009

March 7, 2002

USAID/Egypt
Population and Health Office
Cairo, Egypt

A

TABLE OF CONTENTS

ANNEXES

GLOSSARY OF ABBREVIATIONS

CA	Cooperating Agency (working with USAID)
CDIE	Center for Development Information and Evaluation
CHL	Communications for Healthy Living Project
CPR	Contraceptive Prevalence Rate
CSI	Clinical Services Improvement Project
DHS	Demographic and Health Survey
DHHS	Department of Health and Human Services
EDHS	Egypt Demographic and Health Survey
EFPA	Egyptian Family Planning Association
EPTC	Egyptian Pharmaceutical Trading Company
FP/MCH	Family Planning/Maternal Child Health
FP/RH	Family Planning/Reproductive Health
GOE	Government of Egypt
HM/HC	Healthy Mother/Health Child Project
HPI	Health Policy and Information Project
HSR	Health Sector Reform
HWD	Health Workforce Development project of USAID
IDSR	Infectious Disease Surveillance and Response Project
IEC	Information, Education and Communication
IR	Intermediate Result
IMCI	Integrated Management of Childhood Illness
JSI	John Snow International Inc.
MCH	Maternal and Child Health
MEDTEC	International Medical Technology
MIS	Management Information System
MISA	Ministry of Insurance and Social Affairs (formerly MOSA)
MMR	Maternal Mortality Ratio
MOHP	Ministry of Health and Population
MOI/SIS	Ministry of Information/State Information Service
MOHE	Ministry of Higher Education
MWRA	Married Woman of Reproductive Age
NGO	Non-governmental Organization
PH	Population and Health
PMP	Performance Monitoring Plan
POP IV	Population/Family Planning Project IV (USAID project)
RCT	Regional Center for Training
SIS	State Information Service (Ministry of Information)
SO	Strategic Objective
TAHSEEN	Tahseen Sehetna Be Tanzeen Usretna - Improving Our Health Through Planning Our Families
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
WHO	World Health Organization

USAID/EGYPT POPULATION AND HEALTH SUSTAINABILITY AND TRANSITION PLAN: 2002 - 2009

I. Introduction

A. Purpose of PH Sustainability and Transition Plan

USAID/Egypt's 2000-2009 Country Strategic Plan envisions a nearly 50 percent reduction in resources and staff by the end of the decade. It anticipates a reorientation of the US-Egypt relationship from aid to trade. In the Population and Health (PH) sector, the plan specifies a gradual phase-out of U.S assistance, with all activities ending in 2009. Overall, it calls for a more intense focus on sustainability[1] and suggests the possible creation of legacy institutions to help sustain the many gains achieved through what will, by 2009, be 35 years of USAID assistance to Egypt.

After USAID/Washington's review (February 2000) of the proposed 2002-09 country strategy, USAID/Egypt agreed to prepare, by 2001, a comprehensive transition plan for concluding USAID assistance to the population and health sector. This plan represents USAID/Egypt's proposed 2002-2009 Population and Health (PH) Sustainability and Transition Plan. Overall, its purpose is to guide sustainability planning and transition in USAID/Egypt's population and health sector. Specifically, it:

- Sets forth key achievements to date and anticipated achievements by 2009;
- Identifies key transition strategies and action steps for legacy planning;
- Identifies priority tasks and interventions to sustain the substantial PH gains to date, hence focuses on challenges and next steps related to capacity and sustainability, and less on technical issues;
- Specifies critical benchmarks, transition, and end points in the phase-out of U.S sectoral assistance; and
- Sets forth key indicators for monitoring sustainability and capacity.

B. Overview of USAID PH Assistance

Strategic Objective (SO) 20 reflects a major redirection of the health and population program during USAID's final phase of assistance; it integrates health and population activities to maximize efficiencies, synergies, and impact; broadens its customers to include the whole family rather than just women of reproductive age and their children; and shifts the priority to sustainability. The Strategic Objective, "Healthier, Planned Families," will be achieved through six Intermediate Results (IRs): Improved Family Planning and Reproductive Health (IR 20.1), Improved Maternal and Child Health in Upper Egypt and Urban Slums (IR 20.2), Improved Surveillance and Response to Infectious Diseases (IR 20.3), More Effective Communications for Healthy Living (IR 20.4), More Effective Health Work Force (IR 20.5),

[1] Sustainability, as explained in more detail in Section III, includes the dimensions of institutional, technical, financial capacity and of sustained demand for high quality services.

and Reformed Health Policy and Improved Use of Management and Health Information (IR 20.6). Increased use of services, in turn, will be achieved through increased supply of and demand for quality services; improved knowledge of health risks and practices that lead to positive behavior change; and sustainability of basic heath services that will be achieved through increased NGO and commercial sector participation, strengthened health sector capacity, and improved policy and regulatory environment.

Six interrelated projects will be implemented during the transition period, each contributing to one or more of the above results, and each striving to achieve institutional/technical, financial and demand sustainability. Improving Our Health through Planning Our Families (TAHSEEN), Healthy Mother/Healthy Child (HM/HC), and Infectious Disease Surveillance Response (IDSR) will increase the supply and demand for quality services, thus increasing service utilization. To enhance these three service delivery projects, are three cross-cutting support projects. These include Communications for Healthy Living (CHL), which will promote development of a national public health education agenda and the leadership capacity and partnership to implement it, and provide support to the service delivery projects. The Health Workforce Development (HWD) Project will build the capacity of health providers through improving medical and nursing education; and Health Policy and Information (HPI) project will support health reform and information systems. Overseen by the HPI project, the Healthy Egyptians 2010 Initiative will address other important public health issues, such as accident prevention and smoking.

C. Transition and Sustainability

This plan builds on and aims to apply a wealth of USAID research and lessons learned worldwide on the topics of sustainability, graduation and phase-out. These include:

Sustainability planning does in fact contribute to sustainability. A 1996 USAID CDIE comparative analysis of six USAID-supported FP/RH programs found that those programs that prepared sustainability plans had made greater progress toward sustainability than those that did not.

Cost-recovery often contributes to institutional strengthening and autonomy. During 1994-1996, the USAID-supported Data for Decision-Making Project successfully introduced cost recovery tools and methods into MOHP facilities, and the MOHP continues to make progress on expanding the number of public hospitals operating under cost recovery guidelines. Experience of these cost recovery hospitals has demonstrated dramatic changes in the ability of those hospitals to manage those facilities more efficiently and independently. A 2001 Population Council summary of sustainability research found that almost universally clients are willing to pay more for FP/RH services. (Surveys in Egypt have also documented this finding.) Those institutions that institute fee structures for services are more likely to achieve financial independence, institutional autonomy, and greater capacity than those that provide free or subsidized services.

The achievements of highly successful programs can be quickly eroded in the absence of careful planning and monitoring. In 1989, Tunisia had achieved one of the most successful

family planning programs in the world. Yet by 1992, as documented by a 1995 USAID CDIE study, two years after the conclusion of USAID assistance, family planning users were declining, and other program components (research, training) lacked support. USAID and other donors then mobilized new aid flows to make up the funding gaps. USAID/Tunisia had earlier noted their minimal planning for and monitoring of the phase-out of U.S. assistance.

USAID/Egypt has taken these lessons into account by ensuring that:

- Sustainability planning is a substantial and integral element of the new SO 20 Project and of all its six annual activity workplans throughout the transition period.
- Cost-recovery and fee for service approaches will continue to be tested and findings applied throughout the transition.
- Expansion of commercial sector participation in provision of basic primary health care will help to alleviate the financial burden on the public sector.
- Indicators that reflect progress toward institutional/technical and financial sustainability, as well as sustainability of demand, will be monitored during all phases.

Nevertheless, it is worthwhile to consider the extent to which USAID can sustain change within the health sector in Egypt. Numerous obstacles and challenges exist, including disparities in health status, especially affecting vulnerable groups in the population; inadequate systems to ensure effective operation of health care management and services; limited institutional capacity to implement and improve programs and services; and continued progress in programs, institutions, and health care services. USAID and the MOHP will work together to jointly determine priority issues within the health sector in Egypt. USAID will discuss sustainability issues with the MOHP at every possible opportunity, and will encourage the MOHP to engage in ministry-wide strategic planning in order to determine its priorities and within the health sector as USAID phase-out begins.

II. Vision of Population and Health Sector by 2010 and Expected Results

A. Sector Vision

As 2010 begins and USAID is no longer providing assistance in the Population and Health sector, Egypt can expect to be a middle-income country with reduced levels of donor assistance. The rates of population growth, adult literacy skills, and health and social service capacity in place by that time will be largely determined by investments and resource allocations made in the first decade of this third millennium. What are the expectations for Egypt's health status and population at the end of the strategy period?

Absent a major catastrophe or conflict, Egypt's projected population will be approximately 79 million by the end of the decade, an increase of 12 million from today. Demographers tell us that what can be done to lessen population growth in the coming twenty years is limited, since women and men entering reproductive age are already born and the desired fertility rate has plateaued at 2.9 births for the past 12 years. Cultural and social patterns, including the legal and social status, education, and employment of women, also have been shown to play a determinative role in fertility decisions, and are not likely to change dramatically in the short-

term. Other expectations with a high degree of certainty include: many more births for some years to come in spite of the decline to date in actual fertility rate, though this decline will slow and cease as it continues to approach desired fertility; disparities between Upper Egypt and Lower Egypt are likely to decrease, if not disappear; and Egypt will remain a youthful population, with a bulge in the age cohorts of 10-19 for another decade, though its numbers of surviving elderly will continually increase. Concerning this last point, WHO predicts that like many other developing countries, Egypt will face a "double burden of disease" – from resurgent and new infectious diseases (e.g., viral hepatitis, HIV/AIDS, and drug –resistant TB) as well as from diseases of aging (e.g., cancer and heart disease). Infant, child and maternal mortality rates will continue to decline.

Overall, it is anticipated that by 2010, Egypt will see significant improvements in its sustainable systemic, institutional, technical, and financial capacity to deliver improved basic health care services, and the resulting improved health indicators. However, it must be recognized that by 2010, much room will still exist for needed improvements in the health delivery system and health indicators. Table 1 helps quantify the health status that can reasonably be expected by 2010; Annex C helps identify the sustainability indicators that will be monitored. These achievements depend **heavily** on the assumptions identified in the analysis. The failure of any of these critical assumptions to be realized would jeopardize achievement of the anticipated changes in health status.

Strategic Objective to be accomplished: Decline in population growth and improved health are the primary and complementary objectives of the USAID/Egypt Strategic Plan for 2002-2009. These objectives are captured in SO 20, "Healthier, Planned Families," which is the last planned USAID assistance to Egypt in population and health.

Health Reform and Primary Health Care: The efficiency, equity, effectiveness, and quality of primary health services and resource allocation will improve substantially by 2010 through health reform. Worldwide opinion has coalesced around principles of health sector reform and quality of health care; principles which guide the reform process in Egypt, include USAID, European Commission, and World Bank assistance. Improvements expected from this effort include:

- Delivery of affordable primary health care (including family planning and maternal and child health services) to families from a family practice (the entry level point of contact for all non-emergency care) with a minimum of 25% of the population enrolled in a nearby clinic;
- Provision of a basic package of health services proven to be cost-effective and based upon established medical standards;
- Improved patient satisfaction and willingness to utilize information and services provided (i.e., improved coverage of the poor and vulnerable);
- A national public health agenda led by the MOHP with communication strategies, messages and campaigns developed with the MOI/SIS to educate the Egyptian public and promote adoption of healthier behaviors to address priority public health issues (i.e., safe pregnancy and delivery, pre- and post natal care, birth spacing, family planning, neonatal, infant and

child care, infectious diseases, infection prevention, smoking, accident prevention, and others);

- A stronger MOHP capacity to track and respond to the outbreak of the priority infectious diseases through strengthened surveillance and response capacities;
- An MOHP that is more efficiently, effectively, and rationally managed; and
- An MOHP that is very close to financial independence and much less dependent on donor funds (that is, contraceptive commodities, training expenses, supervision and travel costs, medical equipment and supplies, research and policy development, and other costs currently borne by donors will be covered by the MOHP).

The NGO and commercial sectors and local communities will contribute to greater consumer choice through participation in the provision of basic care, including family planning, and maternal and child health care, and will be eligible to obtain public insurance reimbursement for provision of such basic care to targeted groups. Selected NGOs will play a stronger role in providing consumer and public education. Selected NGOs will be a stronger, more effective force of advocacy for improved primary health care services for the poor. Management of these NGOs, including fiscal management, will be more efficient, effective, and rational. The commercial sector - primarily pharmacies, private physicians and pharmaceutical companies - will play an increasing role in the provision of these same basic care services to clients able and willing to pay. The commercial sector will introduce new products and services, contribute to public health education, and contribute to continuing medical education of pharmacists and private physicians.

These reforms are important to achieving national health objectives and sustainability of USAID-funded programs, since they will: a) result in improved efficiency of care delivery, improved technical and institutional capacities, and improved financing mechanisms and budgets; b) help achieve higher coverage rates with greater impact on health status of the population; and, c) increase public and consumer demand for high quality services.

Family Planning/Reproductive Health: By 2009, the Total Fertility Rate will be 3.3, having gradually decreased from 3.5 in 2000. This and further declines in the fertility rate will be possible only if the desired fertility rate declines below the current rate of 2.9. It is important to note that replacement level fertility of 2.1, a high priority of the GOE and an expressed national goal by 2017, can be achieved only if the rate of fertility decline experienced from 1990-2000 greatly accelerates in the coming decades (a prospect which is by no means assured, and which USAID and other professionals believe to be an unrealistic and unachievable goal). The Contraceptive Prevalence Rate (CPR) will be approximately 70%, and disparities between Upper and Lower Egypt will be reduced. By 2010, the Government of Egypt will be managing the national family planning program without substantial external donor assistance. By 2007, it will be responsible for purchasing all contraceptives distributed through public service delivery outlets, requiring an estimated $11.0 million. The MOHP will cover costs for training, supervision and travel, equipment, and supplies currently funded by donors, as well as continue to fund all costs that it currently covers. By 2007, NGOs will have adequate supplies of affordable and quality-tested contraceptives for sale. The CSI/EFPA network of 85 clinics will be financially independent. Policy analysts and demographers will be providing the necessary analysis, research and information to guide the population program and policy change. The

commercial sector will sell an increasing number of various contraceptive methods, and will introduce new products. The public and NGO sectors will improve their management and accountability to the public.

Maternal and Infant/Child Health: By 2010, rates of antenatal and post-natal care will improve from their low levels, particularly in Upper Egypt. Poor nutrition will improve, breastfeeding will increase, FGC practices will decline, and awareness of the risks of pregnancy and childbirth and the needed healthier behaviors will increase. By 2010, these changes will contribute to lower morbidity and lower mortality rates; the maternal mortality at 50 per 100,000 live births and infant mortality will be approximately 38 per 1,000 live births. Discrepancies between Upper and Lower Egypt in infant and child mortality rates, and access to basic services like pre- and postnatal care, safe delivery, and family planning will be greatly reduced, if not eliminated. By the end of the period, the Government of Egypt will be managing the national maternal and child health program with minimal, if any, external donor assistance. The MOHP will cover costs for training, supervision and travel, equipment and supplies currently funded by donors, as well as financing those costs it currently covers. Selected NGOs will be strong partners in providing these basic primary health services, and will be managed effectively and efficiently. Policy analysts and demographers will provide the necessary analysis, research, and information to guide the national maternal and child health program and policy change.

Infectious Diseases: By 2010, the transmission of the priority communicable diseases will be mitigated through the MOHP's strengthened capacity to track outbreaks of diseases and to respond quickly and appropriately to such outbreaks. By 2006, the nine current fully operational surveillance units will expand to one per governorate. By 2006, the MOHP central and peripheral level laboratories will have improved capabilities needed to support the surveillance units, and the MOHP will have the capability to conduct necessary field studies to complement clinical data sources. By 2006, it is anticipated that Egypt will have the nationwide capacity to respond and protect its citizens from these high priority endemic and emerging infectious diseases. By 2010, the national blood bank will be safe thanks to a functioning blood monitoring system and use of universal precautions in handling blood by blood bank staff in Upper Egypt.

B. SO 20 Strategic Choices

GOE policy towards NGO and commercial providers of health care and NGO advocacy on health issues have not been consistent. At times, the MOHP has taken measures which encourage NGOs and private hospitals. For example, the MOHP pays qualified non-government facilities for renal dialysis services at a rate which covers their recurrent cost, and the GOE has financed and installed renal dialysis units in dozens of private facilities to ensure that all patients experiencing catastrophic renal failure have access to this life-saving intervention. This policy has produced tremendous satisfaction among NGOs and their clients and saved many lives. On the other hand, the MOHP facility planning process often fails to take into account NGO and commercial health care facilities, and proceeds with investment in new public sector clinics and hospital beds under the apparent assumption that they play a negligible role in meeting the needs of the population.

The MOHP has maintained a strategic course where steadily improving quality and marketing of FP/RH services in the public sector have continued to enlarge the MOHP's market share and financial burden at the expense of market share of NGO and commercial providers. USAID's SO 20 made the strategic decision that in the long-run, the GOE and MOHP will need greater - not lesser - NGO and commercial sector involvement to sustain progress towards replacement-level fertility and primary health goals. Consequently, it was determined that substantial USAID resources for services, human resources, and institutional capacity must flow to preserve and strengthen selected NGOs' facilities and services. Specific support would continue to the commercial sector via continuing medical education (CME) to pharmacists and private physicians in the Ask-Consult network, and timely coordinated advertising of family planning products and services, among other activities. USAID also determined that engagement in policy dialogue on issues such as barriers that impede NGO and commercial sector participation and market segmentation to ensure appropriate use of public and private sector services will be very important in achieving efficient use of government resources. Policy makers and planners need detailed, market specific information to address these issues and to improve the enabling environment for NGO and commercial sector participation. USAID has commissioned a contraceptive security study and the findings from that will provide information necessary for attributing market share objectives to –government, commercial, and NGO providers. In addition, the study will estimate GOE recurrent costs for meeting public needs. The proposed Cash Transfer program will provide a forum for effective policy dialogue on the role and regulation of the private sector.

The support from SO 20 means that NGO and commercial provision of care will be strengthened during the current strategic plan period, and that it will help ensure the post-2009 survival of NGOs and market share of NGO and commercial providers through strengthened and on-going institutions and systems, technical capacity, budgets, financial management, and consumer demand. Post-2009 sustainability also depends on supportive partnerships between the MOHP, NGO and commercial sectors; the development of a public understanding of and demand for quality family planning and primary health services from an array of providers; successful health sector reform; viability of legacy institutions; and sustained broader policy dialogue on the role of civil society and the NGO and commercial sectors in health services.

C. Critical Assumptions

The success of the SO 20 program and its sustainability beyond 2009 will depend on the following assumptions:

- Strong political will and GOE commitment continue to place high priority on population and health issues and on health reform, and continue to increase funding levels to support FP/RH and health program as USAID funds taper off.
- Political will and GOE commitment continues to place high priority on fostering an enabling policy environment for the NGO and private sectors.
- Political will and GOE commitment continues to place high priority on funding that supports policies and programs to improve women's social and legal status, level of

education, and employment opportunities that jointly help reduce desired and actual fertility rates.
- GOE's budgetary allocations for primary education and efforts to improve girls' school retention rates continue to increase.
- The GOE continues to make decisions that encourage broad-based economic growth and social stability.
- The commercial and NGO sectors will be able and willing to expand their family planning and reproductive health services and products to appropriate segments of the market, as the government continues to lower barriers to participation.

III. Sustainability and Transition Overview

A. Framework for Sustainability

USAID/Egypt and its partners define sustainability as the equitable, effective, and efficient commitment of institutional/technical and financial resources (both public and private) in ways that continuously respond with high quality services to meet the health needs of the children, women, and men of Egypt. This definition implies that GOE/MOHP, MOHE, MOI/SIS, MISA, USAID/Egypt, and its NGO and private sector partners will address simultaneously over the next decade several dimensions of sustainability:

Institutional/Technical Sustainability – Institutional and technical sustainability includes strengthened systems for procurement of commodities and services, information, management, logistics, human resource planning and development, training, and administration. Strengthened systems must be present in the GOE and NGOs at all levels including community, district, governorate, and central levels, in order to plan, implement, monitor and evaluate high quality family planning and basic primary health information and services. Provision of high quality family planning information and services through the commercial sector will be expanded.

Financial Sustainability – This is consistent, continuous, and more efficient allocation and use of resources, as well as resource mobilization, in the GOE, NGO and commercial sectors.

Demand Sustainability – Demand sustainability refers to better-informed and empowered clients, who understand the relationship of health and family planning to quality of life, are able to articulate their needs for themselves and for their children, and make choices and take actions to address those needs. It also includes better informed health care providers who want and insist on continuing medical education (CME) and certification systems.

Cutting across each of these dimensions is a policy environment that enables and sustains institutional/technical strengthening, financial generation and allocations, and demand generation. USAID/EGYPT, SO 20, and its partners are using this framework to guide sustainability planning. Priority approaches to address institutional/technical, financial, and demand sustainability are outlined below.

B. Sustainability and Transition Strategies

Institutional/Technical Sustainability. Strengthening of systems and structures, and development of human resources in the public, NGO, and commercial sectors are key strategies to achieve institutional and technical sustainability. During the sustainability and transition period, efforts will be made to build on the most important achievements already accomplished in these areas under previous and existing family planning and health projects that are needed to further enhance institutional and technical sustainability of the national FP, MCH, and infectious disease surveillance and response programs. These key achievements should be expanded and disseminated to other geographic areas, institutions and sectors; strengthened; and thoroughly integrated into Egyptian systems at different times under the SO 20 Project. For example, the approaches during the transition period promote strengthening of public sector (MOHP and MOI/SIS) and NGO management systems, including financial, planning, personnel, logistics, supervision, MIS, and others. The approaches also stress the expansion and enhancement of relationships and networks at all levels, including the local level. For example, under SO 20, local community NGO and MOHP staffs will strengthen and coordinate referral networks and planning exercises, and local NGOs, MOHP and the MOI/SIS Local Information Centers (LICs) will increase joint planning and support for local communication events supporting healthier behaviors that address a number of public health issues. In addition, community and district health committees, formed in five governorates, will be mainstreamed into the existing structure of elected bodies: the Executive Council at the governorate level and the Elected Council (which receives funds from the Ministry of Local Development). These community and district health committees will expand into an additional four governorates. At the central level, the MOHP and MOI/SIS will forge stronger integrated approaches to address issues on the national public health agenda.

To improve technical skills and provider capacity, the Sustainability and Transition Plan stresses the improvement of both pre- and in-service training systems and programs. For example, SO 20 will address pre-service training through the HWD project, which will improve the quality and expand the content of the curricula in all public medical and nursing schools to address family planning and maternal and child health. Partnerships between American medical and nursing schools and Egyptian faculties of medicine and nursing will be established to institutionalize exposure to international health experts, and to ensure an ongoing exchange of technical expertise. SO 20 will address in-service training, also through the HWD project, by initiating continuing medical education for physicians, nurses, and pharmacists, expanding the Ask-Consult network activities to update pharmacists and private physicians, and laying the groundwork for an institutionalized health provider certification system. SO 20 will support the Regional Center for Training (RCT), which focuses primarily on in-service FP and MCH clinical training for physicians, to continue on its path towards financial independence. Public and NGO sector pre- and in-service training providers for family planning and maternal and child health services will better integrate, coordinate, and update training regimens and courses. Training packages will expand their curricula to include components on interpersonal communications and client counseling.

Financial Sustainability. The activities under the Sustainability and Transition Plan will greatly expand and improve on the accomplishments achieved to date under former and existing health

and family planning projects, that are needed to: 1) improve fiscal management and decision making in the MOHP and NGO sectors; 2) increase revenue generation in the NGO and MOHP sectors; 3) expand existing health insurance coverage for basic services; 4) expand the role of the commercial sector especially in family planning; 5) encourage continued increases in the MOHP budget; and 6) research possible legacy institutions or mechanisms and implement them where appropriate, as USAID/Egypt's investments decline.

Under the HPI and Cash Transfer Program, it is expected that the health fund which currently covers approximately half of the Egyptian population will become financially viable. The role of the commercial sector will increase with continually expanding sales of current and to-be-introduced new contraceptive methods that serve more of the public that is able to pay for contraceptives in order to assist the MOHP focus its resources on the poor. SO 20 will continue and increase current fiscal management support to the MOHP and selected NGOs with training and improved financial, management, and technical information systems. Successful revenue generation will continue and expand; CSI will continue to sell its FP/RH services and earn service fees under TAHSEEN as it moves towards financial independence. The Regional Center for Training (RCT) also generates revenues and will continue to do so by selling its training services, moving towards financial independence. While resistant to the initiation of a formal fee structure, under TAHSEEN the MOHP will consider analyses of actual costing and pricing activities of FP services in its facilities and projected future costs of the national family planning program. Under the HM/HC project, lessons learned from MOHP hospitals that have successfully recovered recurrent costs will be replicated in others.

Under SO 20, it is essential and expected that the GOE will continue to assume increasing levels of funding to support the national family planning, maternal and child health program, and infectious diseases surveillance and response program. Agreements with the GOE will include these expectations; for example, the GOE which now funds the cost of selected contraceptives, i.e., Norplant, condoms, and oral contraceptives, will also fund and procure IUDs and injectables by 2006. The MOHP will continue to assume the cost of procuring vaccines and make oral rehydration salts (ORS) widely available through its system. The GOE will continue to assure the budget of the Egyptian Pharmaceutical Trading Company (EPTC), a parastatal that graduated from USAID and other donor support a few years ago with management and information systems, and a well and fully trained functioning staff. The MOHP will continue to increase its financial and in-kind support to manage and implement the surveillance system and to respond to disease outbreaks. The MOI/SIS will continue to contribute millions of dollars annually in airtime for mass media to promote family planning, maternal and child health, and additional public health issues. The National Population Council will have to increase its contribution of staff, infrastructure, and operating expenses. These public sector and NGOs will need to develop alternative revenue sources, until by 2009 they are much less dependent on USAID or other donor support. To help ensure financial sustainability of these critical family planning and maternal and child health programs, possible legacy institutions, e.g., local NGOs and binational foundations for endowments of funds or property, will be thoroughly explored under SO 20, and implemented where appropriate.

Demand Sustainability. The SO 20 design recognizes the importance of sustaining demand over time through better informed consumers who will expect and demand access to high quality

primary health and family planning services. It also recognizes the need for well-trained and motivated medical providers who want and insist on access to continuing medical education (CME) and who support institutionalized accreditation systems to further support demand sustainability. The Sustainability and Transition Plan will begin with the accomplishments achieved to date under former and existing primary health, family planning, and infectious disease projects, and expand and strengthen the key achievements needed to generate and sustain client demand for quality services and provider demand for updated training, to encourage positive client and provider behavior change. As a cross-cutting support project in SO 20, Communications in Healthy Living (CHL), will build on the capacity of the public, commercial and NGO sectors to plan, design, and implement communications programs through all types and levels of the mass media at the national and community level.

For the first time, with SO 20 Project assistance, an Annual National Public Health Agenda will be developed to address key public health issues, such as family planning, MCH, infectious diseases, smoking, accident prevention, and more. The MOHP will gain the leadership role to plan, develop, and implement the Agenda in coordination with other stakeholders, such as the Healthy Egyptian 2010 Initiative, the NGO community, MOI/SIS, MISA, commercial interests, and donors. The National Public Health Agenda will more efficiently identify the need for public health issue-specific information, motivational messages, and activities for specific groups in need. The strong ability of the MOI/SIS to develop and air family planning radio and TV spots and programs, developed under previous and current family planning projects, will be expanded to include other public health topics from the National Agenda. With TAHSEEN and HM/HC Project assistance, NGOs will play a more active role in advocacy, community education, and outreach to help increase demand and to encourage community involvement and empowerment. Also, the role of the *raidaat rafiyat* (outreach workers) will be strengthened to enable them to educate and promote positive health behavior at the community level. The mass media and community messages and activities will be coordinated for maximum impact.

Under SO 20, the TAHSEEN project will make linkages with non-health programs such as girls' education, women's literacy, and micro-credit programs to empower girls and women – linkages that have proven to enhance women's behavior change. The commercial sector (pharmaceutical companies) will continue to participate with co-promotional activities for contraceptives that are coordinated to support MOHP FP activities. Private media and advertising firms will participate in developing and airing mass media campaigns. And, policy dialogue will take place to loosen government control over private media. Under SO 20, the HPI Project will help increase public demand for higher quality basic health and family planning services that are available under insurance schemes or otherwise at an affordable cost.

C. Transition Phases

Sustainability and transition are twin concepts that permeate all SO 20 activities in the Transition Plan. During this transition period, only those activities that have proven to be most effective under current projects will be continued, minimizing the introduction of new activities or elements to only those that increase sustainability of systems and results.

The Mission envisions a two-phased program to implement SO 20, followed by post-strategy activities in the third phase. While progress towards sustainability and gradual reduction of funds will be evidenced throughout the program period (2002-2009), there will be a marked difference in the volume and nature of activities and in investments during the life of SO 20. The decline in USAID investments and level of effort will correspond with an increase in local financing and management as programs follow the path to increasing financial and institutional/technical sustainability.

The phases and basic assumptions are described below:

Phase I (2002-2006) extends the current emphasis on sustainability, capacity building, systems strengthening, health reform, policy dialogue, and service delivery to vulnerable and under-served groups. Focus will also include testing integrated models of health care; revising financial, information and allocation systems; and reducing geographic disparities. In addition, legacy planning (e.g., endowments, binational foundations, etc., as described in Section IV) will begin in Phase I and continue throughout the transition period. New and existing activities will be implemented to allow for synchronous implementation through 2006. One project, Health Mother/Healthy Child, is scheduled to end in 2005, the other projects will continue into Phase II, though components of the other projects will end in Phase I. Under TAHSEEN, USAID-funded contraceptives will end in 2005, as will support to the National Population Council (NPC) and the Regional Center for Training (RCT). Support to CSI will end in 2006.

Phase II (2007-2009) signals the precipitous decline of USAID's annual PH funding levels, accompanied by a significant reduction of the "service" support components of SO 20 and a nearly total emphasis on capacity building and sustainability of Egyptian partner institutions, legacy planning and finalization of operational issues, and prioritization of key policy reform measures including more effective private sector oversight. The public sector will assume increasing financial and management responsibility as USAID's support tapers to an end. The remainder of the TAHSEEN Project activities and those of the IDSR, CHL, HWD, and HPI will terminate in 2008 or 2009, with possible Global Bureau assistance secured to complete the phase-out. **Annex A** shows the timeline of transition activities during Phases I and II before final phase-out of the program.

Phase III (2010 – 2011) will represent any post-SO 20 activities necessary to ensure US security and legacy objectives. A skeleton staff will remain at the Mission to complete the final phase-out of SO 20, and to oversee the implementation of any legacy activities. By 2010, it is anticipated that only Global Bureau and legacy (if any) activities will be operating in Egypt. The date of their final conclusion will depend upon final assessments and USG determination on closeout dates of the third phase.

III. Transition Period Activities: 2002-2009

The Government of Egypt and its partners have achieved a wide range of important health results over the past several decades. These achievements, as well as achievements anticipated by 2009, are summarized in **Table 1**, below. This section includes a problem statement and sustainability results to date for each of the six projects. It also focuses on the challenges for

sustaining these achievements for each of the six projects, and important next steps for sustainability planning and implementation. It is believed that such planning will help ensure that positive health outcomes continue to contribute to economic growth and a stable civil society, and that benefits are sustained for future generations.

TABLE 1. Summary of Family Planning and Health Achievements in Baseline Year and 2000 and Achievements Anticipated by 2009

USAID -Supported PH Achievement			
Technical / Support	**USAID-Supported PH Achievements**		
Activity	Baseline Date	2000	2009
Improving Our Health through Planning our Families (TAHSEEN)			
1. % of currently married women who know any contraceptive method.	90% (1980)	100%	100%
2. % of currently married women using modern contraceptive methods (CPR).	24% (1980)	54%	63%
3. Total fertility rate (TFR).	5.3 (1980)	3.5	3.3
4. Unmet need for family planning.	20% (1992)	11%	5%
5. No. of Gold Star clinics (which comply with health quality standards).	0	1,875 (45% of 4,200 MOHP clinics)	3,500
6. No. of CSI clinics (known for high-quality clinical FP services).	0	88	88
7. Reducing disparity between Upper and Lower Egypt:			
a. CPR: Upper Egypt/Lower Egypt	17%/34% (1984)	45%/62%	60%/71%
b. TFR: Upper Egypt/Lower Egypt	5.4/4.5 (1988)	4.7/3.3	4.1/3.0
a. Unmet need: Upper Egypt/Lower Egypt	28%/18% (1992)	16%/9%	7%/4%
Healthy Mother/Healthy Child (HM/HC)			
1. Infant mortality rate (IMR).	132 (1980)	44	38
2. Maternal mortality ratio (maternal deaths per 100,000 live births – MMR).	174 (1992/93)	84	50
3. % of children 12-23 months fully immunized.	67% (1992)	92%	95%

USAID -Supported PH Achievement			
Technical / Support	**USAID-Supported PH Achievements**		
Activity	Baseline Date	2000	2009
4. % of births whose mothers received four or more antenatal care.	23% (1992)	37%	46%
5. % of pregnant women with Tetanus Toxiod Coverage.	57% (1992)	73%	80%
6. % of births attended by medical providers.	35% (1988)	61%	65%
7. Reducing disparity between Upper and Lower Egypt:			
a. IMR: Upper Egypt/Lower Egypt	174/110 (1980)	71/45	61/38
b. % of births attended by medical Providers: Upper Egypt/Lower Egypt	24%/31% (1988)	48%/65%	51%/69%
Infectious Disease Surveillance And Response (IDSR)			
1. No. of governorates with Epidemiology and Surveillance Units established.	0 (1999)	9 (2000/2001)	27
2. No. of Trained Epidemiologists.	15 (1999)	27 (2000/2001)	48
3. No. of 102 Fever Hospitals that pass standardized assessments of microbiology capacity.		13	41
4. No. of districts reporting on 21"reportable prioritized diseases" up to the central level.		191	267
Communications for Healthy Living (CHL)			
1. % of low parity (0-2) women using contraceptive method.	26% (1988)	44%	60%
2. % of women who do not support female circumcision	82% (1985)	75%	66%
3. % of births spaced more than 23 months.	74%	76%	80%
4. % of women who recognize danger signs of pregnancy.	TBD	TBD	TBD
Health Workforce Development (HWD)			
1. No. of 14 medical and 11 nursing	0	14 medical	14 medical

USAID -Supported PH Achievement			
Technical / Support	**USAID-Supported PH Achievements**		
Activity	Baseline Date	2000	2009
schools adopting competency-based curricula in 4 areas.		schools (1 area) 13 nursing schools (1 area) (2002)	schools (4 areas) 11 nursing schools (3 areas)
2. No. of teaching staff members trained on new teaching methodology.	NA	50 (2003)	250 (2007)
Health Policy and Information (HPI)			
1. % of population covered by government -provided health insurance.	38% (1999)	42%	56%
2. No. of public health facilities operating under cost-recovery model.	12 (1997/1998)	35	260
3. % of MOHP expenditures devoted to primary health care/preventive medicine.	25% (1995/96)	42%	60%
4. No. of entities accredited and contracted to provide Family Health.	0 (1999)	3	100

A. Family Planning/Reproductive Health

USAID/Egypt's final FP/RH program will be supported through an initiative especially focused on sustainability, and hence is named Improving Our Health Through Planning Our Families - TAHSEEN. This is a nationwide program that will focus on reaching the under-served geographic areas and populations, i.e., Upper Egypt, urban squatter settlements, youth, postpartum women, unempowered women, etc.

1. Problem Statement. Egypt's critical problem remains population momentum. Higher fertility rates in the past means that the largest generation ever of Egyptian young people is just now entering their reproductive years. Over the next 20 years, the number of married women of reproductive age will grow by about 40 percent (from around 10 million to 14 million in 2020). At current fertility rates, 1.7 million people are added to the population annually, requiring a substantial increase in all services and resource allocations. With more families to cover, the family planning program will need to achieve new levels of effectiveness and efficiency solely to continue reaching 54% of the population, the current rate of modern contraceptives use. Additional resources and efficiency will be imperative if the percentage of users increases.

Given Egypt's national goal of achieving replacement level fertility (2.1) by 2017, a goal consistent with a contraceptive prevalence rate of approximately 75 percent, significant additional resources in all categories -- financial, institutional, technical, management/administrative -- will be needed to increase family planning use by 1 percent annually just as USAID assistance is ending. However, achieving this high level of

contraceptive use will not necessarily ensure the achievement of the governments stated goal of replacement level fertility. A significant barrier to achieving replacement level fertility, particularly by 2017, is the desire of Egyptian families to have more than 2.1 children. Desired fertility in Egypt has not consistently declined, and has actually increased in past years; TFR was 2.7 in 1992, declined to 2.6 in 1995, and then increased to 2.9 in 2000. Ideal family size, another similar and telling indicator, has remained stagnate at 2.9 children since 1988. Average family size barely changed between 1995 to 2000, i.e., decreasing from 3.6 to only 3.5 children. Additionally, 18% of women over 35 years have more than three children, and will also need family planning support to help them avoid unwanted pregnancies.

Various factors will determine whether Egypt can achieve a decrease in desired family size, an increase in family planning service utilization, and movement toward replacement level fertility. Necessary budget increases from the GOE and improved performance of the national family planning program will not be sufficient. Other social factors play a significant role in desired and actual fertility and use of services; for example, women's social and legal status, educational achievements, and employment opportunities and levels. To address these important social factors, the GOE will need to increase budgetary allocations for girls' education and other social programs that benefit women; improve employment opportunities for women; and ensure significant improvement in policy and laws that affect the social and legal status of Egyptian women. Global research has revealed that women's education is a critical determinant of desired and actual fertility and use of family planning services. Unless the lives of Egyptian women progress in these directions, desired family size will most likely remain at current levels of 2.9 – a threshold that looms as a major obstacle to the government's vision of achieving replacement level fertility.

Young people's use (or lack thereof) of FP/RH services will decidedly shape the population growth rate and Egyptian development trends (i.e., income per capita, population density, unemployment, civil unrest, resource availability) in the first three decades of the 21st century and beyond.

Another significant aspect of the problem is the disparities between Upper and Lower Egypt. CPR is 61% in Lower Egypt compared to 42% in Upper Egypt and 37% in rural Upper Egypt. Family size corresponds with an average of 3.24 children in Lower Egypt, 4.24 in Upper Egypt and 4.7 in rural Upper Egypt. Unmet need for family planning is higher in Upper Egypt (51%) compared to Lower Egypt (35%). In both Lower and Upper Egypt, the level of unmet need is much higher in rural areas compared to urban ones.

2. Sustainability Results to Date. Over the past thirty years Egypt has achieved universal knowledge of family planning, has more than doubled modern contraceptive prevalence (to 54% for modern methods), and has reduced the total fertility rate by nearly one third (to 3.5). Very high levels of physical access exist as a result of dense coverage by clinical facilities throughout the nation, and through affordable, quality services available from public, NGO, and commercial providers. There is strong and continuing commitment to the program at all levels of the Egyptian government, including the President and the Cabinet. Sustainability achievements include the following:

Institutional/Technical Sustainability – More than 4,200 public clinics are trained to provide FP/RH services, 1,800 of which have achieved the Gold Star status. Quality standards and protocols have been developed and adopted by MOHP clinics nationwide. Eighty-five NGO clinics through CSI/EFPA provide high quality services. MOHP district level warehouses for commodities are fully functioning. MOHP and CIS financial and other management information systems have been developed, are functioning, and are increasingly used for management decision- making. The Egyptian Pharmaceutical Trading Company (EPTC), a parastatal pharmaceutical distribution company, distributes 90 percent of the nation's contraceptives to the public NGO and commercial sectors. The Regional Center for Training (RCT) was developed as a training center that provides quality in-service clinical FP/RH training to physicians. An updated and standardized FP/RH curriculum was recently developed and put into use by all 14 medical schools. There is evidence of the MOI/SIS' capacity to plan and contract out FP/RH mass media campaigns and products to commercial advertising companies. A functioning network of 13,500 pharmacists and more than 4,000 private physicians provides members with updated FP/RH training and information. Commercial sales of contraceptives are steadily increasing. New FP products are introduced through the commercial sector, though the pace of introduction is still hampered by lengthy and by byzantine procedures for licensing and registration. Policy changes were made that resulted in a significant decrease of tariffs and taxes on imported IUDs and condoms.

Financial Sustainability – The MOHP has assumed financial responsibility for procurement of condoms, NORPLANT, and oral contraceptives. The MOHP provides staff salaries, operational expenses, and infrastructure in support of the national family planning program. A new line-item for contraceptives was created in the MOHP budget in 2000. The EPTC operates under GOE subsidy without major donor support. The MOI/SIS contributes significant free and reduced air time to promote FP/RH, and pays for half of all production costs for TV and radio spots, ads, and programs. It also provides staff salaries, operating expenses, infrastructure for FP/RH mass media, and community education through 65 Community Information Centers. RCT has increased the marketing and sales of its training programs. The CSI/EFPA clinics have assumed more of their costs, covered in part by US$1.0 million (LE 4.27 million at the exchange rate of US $1/ LE 4.27) annual revenue generation.

Demand Sustainability – The increase in utilization of FP services has resulted in a significantly higher CPR and lower TFR compared to a decade ago. The long-term trend toward incremental increases in demand for family planning is evident.

3. Remaining Challenges for Sustainability. Remaining challenges for sustainability and steps to address them under TAHSEEN include:

A. Low level of services for and outreach to priority groups.

The most significant priority group in terms of numbers is the large number of young people entering their reproductive years. Outreach to this age cohort will be critical to sustaining future demand and use of services. Outreach to youth and married adolescents with low literacy and education levels will not be easy. A desired family size of three or more children and intense social pressure to have a child as soon as possible after marriage remain serious

obstacles to lower levels of fertility. In a sample of married adolescents, 52 percent reported never having attended school. Contraceptive use among newly married couples is practically nil, less than 1%. Further, only 35% of women with one child utilize family planning services, and even fewer women with two children (16%) take advantage of them. Other difficult to reach priority groups include postpartum women, women in need of post-abortion care, women medically qualified for a tubal ligation, unempowered women, and women in specific geographic regions (i.e., rural Upper Egypt and urban squatter settlements in Alexandria, Cairo, and Port Said which constitute an average of 30 percent of their respective populations). Urbanization brings with it new problems; for example, rural migrants who flock to the urban squatter settlements often leave behind the social support in the rural areas and consequently make new demands on the health care system in urban settlements. The **challenge** for the next decade is to build further demand for FP/RH, particularly among the priority groups noted above, and ensure that safe and effective FP/RH services are in place to meet that demand.

B. Inappropriate balance between public, commercial and NGO sectors.

The public sector's share of the FP/RH market has been growing since 1992. Both the NGO and commercial sectors' shares of FP users declined during that time, from 63% to 51%, for all methods. The public sector currently provides slightly more than half, 54% of IUDs, while the commercial sector provides 81% of orals. In the public sector clinics, the low number of average daily number of visits (estimated at 3.8 family planning clients) is inefficient, and is resulting in resources wasted on underutilized clinical capacity. The public sector does not provide a discriminating "social safety net" for the poor or have data-based, rational fee policies for FP clients. For example, secondary analysis of EDHS 2000 data indicates for the public sector FP fees, approximately 65% of all clients, from the poorest to the most well off, pay full FP fees. Furthermore, the majority of FP clients who are eligible for subsidized FP/RH services are either able or willing to pay more for the services. This situation can only lead to an increased financial burden on the public sector budget, as FP costs will become increasingly untenable as demand increases and donor support declines. Experience worldwide shows that a division of roles and responsibilities among the three sources of care (public, commercial, and NGO) leads to greater efficiency, coverage, demand, service use and sustainability. Further, public sector dominance of market share will lead to stagnation in national coverage, and will result in failure to reach the objectives stated in the GOE's "Vision 2017" National Plan. The **challenges** for the next decade will be to balance the market share among the three sectors by fostering greater NGO and commercial sector participation, and addressing the public sector's budgetary and financial sustainability under the current policy of providing subsidies for all clients, even those who can afford to pay.

C. Policy Environment and Decision-Making Processes are not Conducive to Expanding National Family Planning Programs.

The policy environment and the political decision-making process currently present obstacles to the success of the national FP program. It does not currently favor appropriate market segmentation to enable greater efficiencies and cost recovery, encourage appropriate expansion of the NGO and commercial sectors, manage and plan human resource needs such as determining and hiring the correct number of physicians and nurses, enable sufficient

governmental regulation of NGO and commercial providers, and more. The **challenge** in the next decade is to enhance, expand and strengthen the policy environment and political decision-making process.

D. Inadequate and not yet sustainable institutional capacity and systems.

The public sector is responsible for ensuring contraceptive security for public providers during the gradual, planned phase-out of USAID financing. The MOHP currently finances condoms, NORPLANT, and oral contraceptives; however, by 2006, it will need to also finance all IUDs and injectables for the public sector at an approximate cost (at USAID prices) of $11.0 million annually. The MOHP may need to fund or subsidize contraceptives for most, if not all, of the NGO sector, or develop an affordable means for NGOs to do so. Management capacity within the MOHP and the NGO community needs improvement in many areas: continuous quality improvement and problem-solving, financial, planning and analysis, innovative motivation and compensation schemes, performance criteria definition, human resources development and management, and MIS integration and use in planning and decision making. Sustainable systems to ensure updated and high level technical capacity for physicians, nurses, lab technicians, outreach workers, and others are not yet fully established. The **challenge** over the next decade is to ensure these systems are fully operational and sustainable.

E. Inconsistent quality of FP services for the customer.

Research worldwide shows that improved quality responsive to client needs leads to increased demand and higher service use. One **challenge** is to continue raising clinical quality levels in the MOHP while simultaneously introducing a "culture of quality" in the commercial and NGO sectors. Improving quality will also necessitate a better understanding of the client's definition and perception of quality and the ability of the provider to meet it. Improving quality will also mean advancing service integration within the MOHP, and working closely with other SO 20 projects. Full client choice from a wide variety of methods available through the all three sources must be expanded and ensured. Finally, interpersonal communication between providers and clients must be improved to ensure client understanding and ability to seek information.

4. Next Steps for Sustainability.

Institutional/Technical Sustainability – TAHSEEN will support systems strengthening and capacity building activities in the public, NGO, and commercial sectors. TAHSEEN will strengthen MOHP capacity to plan at all levels, including planning for contraceptive independence. Activities towards commodity sustainability will include the implementation of a Contraceptive Security Study (January-May 2002), which will examine anticipated costs for contraceptive security under various options. The options for each contraceptive are overlapping and include: (a) GOE/MOHP import of contraceptive commodities; (b) support of local parastatal GOE subsidized production; (c) unfettered local commercial importation; (d) unfettered local commercial production; or (e) a combination of options. The analysis will guide USAID/Egypt's commodities planning and phase-out for the transition period, and will enable the GOE to make informed decisions on how it will finance and ensure contraceptive

security. TAHSEEN will also strengthen the MOHP and NGO capacity to better use their MIS and data for decision-making, appropriately determine and fill MOHP staffing needs for its national FP office, and assist the MOHP to integrate its FP, RH and MCH services at the local clinic level.

TAHSEEN will assist the MOHP in increasing and strengthening its collaboration and teamwork with selected NGOs and the commercial sector, including improved monitoring of standards in the NGO and commercial sectors. TAHSEEN will also strengthen several NGOs' capacity for education, referral, outreach, and clinical services. NGO activities will help women and men of all ages understand the relationship between FP/RH and quality of life, as well as their range of options and choices. TAHSEEN will assist the commercial sector in institutionalizing the network among pharmacist and private physicians; will assist in increasing the sale of FP/RH products; and will aid in educating the providers to continually improve the quality of services.

Financial Sustainability – TAHSEEN will assist in the development of strategies and identification of policy dialogue issues for facilitating expansion of the commercial and NGO sectors; aid the MOHP with analyses and studies to project likely budget needs for commodities; assist the MOHP with data analyses on pricing issues, other revenue generation issues, and financial efficiency; help CSI/EFPA to expand and ensure its financial independence; assist the RCT in addressing its financial sustainability issues; and research the possible role of legacy institutions and endowments.

Demand Sustainability – TAHSEEN will help the three sources of FP/RH care play a key role in generating demand for health services, particularly among high priority groups. Activities to sustain demand include: (a) use of outreach and information strategies with MOHP, commercial, and NGO partners to reach youth, engaged couples, newlyweds, and low-parity women; and, (b) identification of NGO partners for education, outreach, referral to clinics, and linkage to non-health NGOs. Commercial sector advertising will also contribute to demand sustainability. TAHSEEN will help the MOHP work more closely with the MOI/SIS in identifying and coordinating mass media and community events to increase client demand. TAHSEEN will assist the MOHP to better coordinate and lead other players, such as the Ministries of Youth, Women, Information, Education, Culture and Social Affairs, Economics, and the like to better impact social factors, GOE programs, and policies that affect desired and actual fertility.

B. Healthy Mother/Healthy Child

1. Problem Statement. Despite tremendous progress made in improving maternal and child health status, further improvement is needed and possible. Significant disparities remain between rural and urban, and Upper and Lower Egypt. The national IMR declined from 63 in 1995 to 44 in 2000, and under-five mortality rates from 81to 54 in the same period. However, infant and under-five mortality rates in rural Upper Egypt are about 30% higher than in rural Lower Egypt. Deaths during the neonatal period represent 55% of overall infant mortality, and remains the biggest challenge for achieving lower infant mortality. Only 37% of women receive four or more prenatal visits, and only 61% of deliveries are medically assisted.

The most important constraints that impede further progress in improving maternal and child health status are systemic in nature: poor and unempowered women lack access to quality reproductive and child health services and information, especially in remote areas; inconsistent or low quality of services; unregulated standards for care in the commercial sector; weak referral systems; and lack of essential clinical and counseling skills among medical graduates.

2. Sustainability Results to Date. There has been remarkable progress in the health of mothers and children over the past eight years. During 1992 - 2001, Egypt maternal mortality declined dramatically (from 174 to 84 per 100,000 live births); and it is notable that the MMR for Upper Egypt now nearly equals that of Lower Egypt. Reductions have also occurred in neonatal mortality (from 33 to 24 per 1,000 live births) and in infant and under-five mortality as mentioned above. Polio is almost eradicated, with only five polio cases detected in 2001, reduced from 75 in 1995.

Institutional/Technical Sustainability. In the first phase of the Healthy Mother/Health Child Project (1995-2001), USAID's principal strategy was to reduce maternal and child mortality in 25 high-risk districts in five governorates of Upper Egypt. During the second phase of HM/HC, up to an additional 50 districts in four additional governorates will be covered. During the first phase, the HM/HC project focused on improving the basic essential obstetric and neonatal care services in the five target governorates. Service standards and clinical protocols were developed and are being published by the MOHP for nationwide use. In the five target governorates, lead trainers were trained to supervise local health providers. Quality assurance and supervision systems were established, and district and governorate teams were trained in planning and health management skills. Systemic changes in the five target governorates included strengthening decentralized capacity through community and district health committees that develop health plans; establishment of district level information centers to improve access to computerized health statistics for informed decision making; and expansion of the Integrated Management of Childhood Illness (IMCI), an integrated program including all childhood "vertical" programs. The IMCI program assists in proper management of childhood illnesses, eliminates duplication of training and management structures, and promotes the rationalization of drug use.

Financial Sustainability - The 1997 MOHP Ministerial Decree No. 239 provided the mandate for cost recovery. Hospital administrations, however, show considerable differences in abiding by the decree. USAID, through its technical assistance contractor, John Snow International (JSI), assisted in sharing this information in the five target governorates, and trained hospital staff at 25 hospitals on management skills. The MOHP also approved a decree that permits the renovated maternity centers in primary health care clinics to charge for normal deliveries. All 70 centers renovated and assisted by the HM/HC project have been encouraged to use this policy. The MOHP made progress in meeting costs previously paid by donors; e.g., the annual $40.0 million cost of vaccines, $3.0 million cost of disposable syringes, and $4.5 million cost of ORS for public facilities. ORS is also widely sold throughout the commercial sector at government subsidized prices. The Human Resources Department of the MOHP has been allocated an increased budget of approximately LE 7-10.0 million in the past year. This budget is helping pay for in-service training in maternal and neonatal care for MOHP physicians.

Demand Sustainability – HM/HC promotes appropriate health seeking behavior in households. Two national campaigns were conducted and several education materials were developed covering a variety of maternal and child health issues. In five target districts, 100 community activities were initiated with elected village councils. JSI developed partnerships with 100 NGOs to promote positive health-seeking behavior, especially in the areas of safe delivery, obstetric emergencies, and neonatal care. Approximately 245 private physicians and 628 pharmacists in the five districts were included in an orientation course and were provided protocols developed by HM/HC. The HM/HC pilot project tested the development of linkages with the national adult literacy program in 30 classes in one governorate, partially addressing the issue of women's status. It was expanded to two additional governorates. These activities resulted in increased service utilization in the five target districts as shown by the statistics in the district health monitoring system and national level 2000 EDHS results. Local studies following the two national campaigns showed an increased knowledge of maternal and neonatal warning signs.

3. Remaining Challenges for Sustainability. Rural Upper Egypt continues to have higher preventable mortality, and challenges remain in reducing maternal, perinatal, and childhood deaths. Pockets of higher mortality also exist in Lower Egypt, such as in urban slum settlements. By lowering the maternal mortality rate in Upper Egypt to approximately equal that of Lower Egypt, HM/HC has demonstrated that it is possible to close geographical disparity in a relatively short time. However, poor infection control practices continue to be a challenge that keeps the neonatal mortality rate at a high level. Lack of practical clinical skills among medical graduates is an overriding concern and a major sustainability issue. Low women's status affects knowledge of health risks, health seeking behavior and utilization of health care.

4. Next Steps for Sustainability. The extension of the HM/HC Project (2002-2005) will focus on sustaining gains to date in the five target districts, and addressing remaining challenges. It will also expand and support the original goals of reducing infant and maternal mortality; closing geographical disparities; and expanding its maternal and neonatal program to an additional four governorates with up to 50 additional districts, and to approximately two selected slum areas of Lower Egypt. It will assist the MOHP in expanding the IMCI program from the 32 districts covered in the first phase, to an additional 123 districts spread throughout all 27 governorates. HM/HC will continue to support the national immunization program to maintain high levels of immunization coverage and to achieve polio eradication by 2003.

Institutional/Technical Sustainability – HM/HC will assist the MOHP in strengthening its decentralized management and planning capacity, institutionalizing its standards and protocols, improving its clinical competence, improving its systems development, and fostering partnerships between the MOHP and local NGOs. It will assist the MOHP in mainstreaming and institutionalizing management and planning skills for safe motherhood at all levels, by linking with the elected Councils at the governorate, district, and community levels. HM/HC will aid the MOHP in adoption of facility standards and protocols for nationwide hospital use and in incorporation of new obstetrical and neonatal facility standards and protocols into most Upper Egypt district hospitals (75 of the total 81 hospitals) and in a selected few primary health

care facilities in the Giza district. HM/HC will be responsible for assisting the MOHP in developing its in-service MCH training program for providers. The MOHP's Curative Care Department (CCD), responsible for hospital services, will continue to be included in all implementation and supervision activities, and will assume a major responsibility for sustaining these activities.

Financial Sustainability – HM/HC will help all 75 district hospitals and 150 maternity centers and delivery rooms of Upper Egypt learn and replicate lessons from the successful experiences of the Health Services Improvement Fund, covered by the Ministerial Decree noted above.

Demand Sustainability – IEC materials will continue to be utilized in coordination with the CHL Project. Linkages with the adult literacy program, piloted in the first phase of HM/HC, will be replicated and expanded in the second phase. Partnerships with additional 70 NGOs under JSI and 25 NGOs under the NGO Service Center Project will promote positive health–seeking behavior, such as increasing the number of antenatal visits. Promoting proper breastfeeding practices, seeking appropriate care with neonatal and pregnancy related emergencies, and reducing harmful practices such as FGC will also be addressed.

C. Infectious Disease Surveillance and Response (IDSR)

1. Problem Statement. Infectious diseases that once appeared to be well controlled are resurgent globally, and new infections are occurring. Several infectious diseases have reappeared as threats to public health in Egypt; among them are tuberculosis, viral hepatitis, and HIV/AIDS. Egypt faces many communicable diseases that threaten the health of its citizens, lower life expectancy, and increase demand for expensive curative care. Diseases of significance in Egypt that USAID will help to address include: TB, HIV/AIDS and other reproductive tract infections (RTI), viral hepatitis, schistosomiasis, and other blood-borne diseases. Uncontrolled epidemics not only harm individuals and families, but they also negatively impact economic development, tourism, commodity exports, foreign investment, and regional relations.

2. Sustainability Results to Date.

Institutional/Technical Sustainability - Prior to 1999, Egypt did not have a comprehensive disease surveillance system in place, and regular ongoing surveillance was lacking. Since 1999, technical support has assisted the MOHP to create such capacity with a current system that covers 9 selected high-risk governorates (5 in Upper Egypt and 4 in Lower Egypt) and 23 priority diseases. Plans to expand it to the other 18 governorates have been initiated. A cadre of 36 professional epidemiologists, trained under earlier USAID projects, is in place and functioning. Surveillance reports are regularly produced for the 9 governorates and used to determine appropriate public health interventions. Initial research on a promising vaccine candidate for schistosomiasis is being tested, and the GOE will take over the research in 2002.

Financial Sustainability – The MOHP has been providing in-kind contributions to the IDSR activities, such as training facilities, and offices for field epidemiology units. It also pays for

the recurrent costs of all epidemiology units, HIV/AIDS and other infectious diseases activities and interventions, reagents, supplies and equipment.

Demand Sustainability – Demand sustainability is presently stronger among the service providers than among the general public. The strategy to improve the communicable disease surveillance in Egypt is based on an external review conducted in March 1999. Recommendations from this review were based on the perceptions and needs of health care providers, who suggested that an upgrade in epidemiology capacity include the development of district, governorate, and central surveillance activities, and the establishment of an electronic reporting system at all levels. Providers in all the governorates and districts took the initiative and responsibility, under MOHP leadership, to help design improvements in the current standard operating procedures used for infectious diseases identification and referral. Leaders at the district and national level also called for the integration of numerous surveillance activities (including TB, HIV, polio and others) into a comprehensive surveillance program at all levels. Health clinics, in turn, have begun to educate the communities they serve about the most salient infectious diseases on the prioritized list, as well as the benefits of safe injections and the use of universal precautions.

3. Remaining Challenges for Sustainability.

a. The national capacity to undertake disease surveillance and response is presently limited to nine governorates. In order for Egypt to protect its citizens from endemic and emerging diseases, a strong network of disease surveillance and response is needed. Districts in each governorate will report to the corresponding epidemiology center in their governorate, and all 27 governorates will report to the Epidemiology and Surveillance Unit (ESU) in the MOHP. While the system described above will serve as a strong foundation for the collection and dissemination of pertinent infectious disease data, the real strength of such a system lies in the ability of MOHP staff to make logical response decisions based on evidence of an outbreak. This decision making process will need to be further operationalized.

b. Building HIV/AIDS awareness and HIV/AIDS program capacity is needed, despite the fact that the HIV/AIDS epidemic in Egypt is still classified at a "low level." By the end of 1999, an estimated 8,100 adults and children were living with HIV/AIDS; however, because of gaps in reporting and diagnosis, these officially reported cases likely represent only a portion of all cases. If Egypt is to avoid a tragic increase of HIV/AIDS to epidemic proportions (as happened in many other countries), the issue should be effectively addressed while HIV/AIDS is at nascent stage.

4. Next Steps for Sustainability.

Institutional/Technical Sustainability - IDSR will assist the cadre of 36 epidemiologists in training at each governorate and district level, as well as in the 102 Fever Hospitals. This surveillance capability will be in all districts and governorates nationwide by 2005, and will be fully financed and managed by the MOHP. IDSR will assist the MOHP's National AIDS Program collaboration with the Ford Foundation to improve the National HIV/AIDS Hotline, increase diagnostic capacity, conduct population-based prevalence surveys, and train a larger

cadre of health care providers in HIV/AIDS management. As a first step in building institutional sustainability to address HIV/AIDS, IDSR will assist the MOHP address the limited information and knowledge about HIV infection, disinfection procedures, and clinical manifestations among the general medical community in Egypt through training. Once the training is completed, USAID will continue to provide specified technical assistance. IDSR will also support NGOs working with groups at high-risk of HIV/AIDS and to raise general community HIV/AIDS awareness.

Financial Sustainability - The GOE is currently providing in-kind and cash support to the surveillance system that now covers 9 districts, but will need to assume all costs for the system to cover all 27 governorates by 2005. The necessary documentation to create a line-item in the MOHP budget for the epidemiological surveillance units has been prepared, and the MOHP is committed to gradually assuming these costs. Beginning in 2006, IDSR will provide only limited technical assistance to the HIV/AIDS Hotline and the epidemiology program. Additionally, USAID will continue to discuss strategies to improve surveillance and ensure sustainability.

Demand Sustainability - With increased awareness, public demand for services increases; such is the case with the National HIV/AIDS Hotline. The most effective advertising for the Hotline is the weekly advertisement spot in the two major daily newspapers in Egypt. Billboard and posters on buses and the Metro are also used. The volume of calls correlates to advertising; increases are dramatic, from 8-10 daily calls to more than 60 per day for several days following the weekly newspaper ads. The demand for confidential HIV testing and counseling, also provided at the Hotline site, also increases. IDSR will assist the MOHP inform and educate the general public about the priority communicable diseases, as well as the need for the use of universal precautions.

D. Communications for Healthy Living (CHL)

1. Problem Statement. Limited awareness of health information contributes to ill health and mis- or under-utilization of basic health services, including family planning. A major concern for SO 20 is the stagnation of desired family size for the past 12 years at 2.9 children per woman. If desired fertility does not decline, achievement of replacement fertility rate of 2.1 will be unlikely. It will also likely result in negative effects on the welfare of the Egyptian population in areas of health, education, public services, and economic growth. Other areas of concern include high discontinuation rate (30% within 12 months) for family planning methods, high proportion of child deaths from acute respiratory infection and diarrhea (50%), high proportion of neonatal deaths, limited and declining use of Oral Rehydration Therapy (34%), low rate of antenatal care (37%), less than desirable rate of exclusive breastfeeding (68%), high proportion of women who have had female genital cutting (97%), one of the world's highest prevalence rate of Hepatitis C (due to unsafe injection practices), and very low treatment-seeking behavior for sexually transmitted diseases. Gender barriers continue to remain a problem that affects girls' and women's social, legal, educational, and employment status. Due to poor diet, almost half of the adolescents are anemic; smoking frequently begins at a very young age; and motor vehicle accidents and burns are common causes of death among youth.

More effective leadership is needed to assess, develop, coordinate, and oversee a national public health education agenda, one of several very necessary components required to help change numerous health behaviors for a positive health impact. The various medium and resources currently used for public health education, including human resources, funds, equipment, mass media, community health events, and others are not coordinated. The diverse use of TV and radio airtime, printed and poster materials, and community events to promote and discuss health topics has not been driven by an overall, thoughtful public health strategy.

2. Sustainability Results to Date. During the past 25 years, a number of IEC and capacity building initiatives have been supported by USAID/Egypt that have started the communications program on the road to sustainability.

Institutional/Technical Sustainability: The family planning and population projects supported by USAID developed numerous national mass media campaigns and local community events, and trained providers on interpersonal counseling. These contributed to the nearly universal knowledge of family planning, a large increase in contraceptive prevalence, and a significant decline in fertility. USAID assistance also trained MOI/SIS staff to implement FP/RH/population mass media campaigns through subcontracting and managing of local advertising firms to develop TV and radio spots and programs, posters, and other printed materials to increase coverage of FP/RH topics in ongoing programming; to generate expanded press coverage of important population news and events; and to present local FP/RH events through community groups all over Egypt.

Financial Sustainability: For many years, the MOI provided a substantial amount of free TV and radio broadcast time for family planning and population messages and half-price airtime to promote the Clinical Services Improvement Project/EFPA. The MOI/SIS also pays for office space, operational expenses, salaries, and half of the subcontracting costs to develop the TV and radio spots and programs. The commercial sector has begun to pay some of the costs of co-promotional advertising. The commercial sector, MOHP, and the MOI/SIS are coordinating the introduction of new FP products and airtime promotion to maximize customer impact. If the current state-owned TV and radio network is privatized in the future, as is currently under discussion, the large amount of past and current free TV and radio airtime may be threatened, if the GOE finds it more difficult to meet private sector airtime advertising prices than to provide free state-owned airtime.

Demand Sustainability - The Diarrheal Diseases Project used a combination of mass media and interpersonal communications to change both household and provider behavior on the use of oral rehydration salts (ORS), saving many lives. In recent years, the communications informing and urging the public to use ORS has greatly declined, along with a decrease in the actual use of the product. This is noted as an example of the fact that on-going use of mass media and interpersonal communications is necessary to continue impacting health behavior in a positive way. Later, the Child Survival Project urged families to immunize their children to seek neonatal care, and obtain prompt care for respiratory infections, resulting in very high public demand for immunization services and health care services. More recently, the HM/HC project mounted two national campaigns to increase use of obstetrical services for emergencies and to promote better neonatal care; exclusive and early breastfeeding; antismoking messages; and iron

supplementation among school children. Early results indicate that these are becoming integrated in the public demand for better health care. The Population Projects I, II, III and IV generated high public demand for family planning services, resulting in increased contraceptive use, increased spacing and limiting of unwanted pregnancies, decreased fertility, and decreased neonatal, postnatal, child, and maternal morbidity and mortality. Although USAID believes the sustainability of demand for either child vaccinations or family planning services is unlikely to decline, much less disappear, given the enormity of each ones' impact on individual and family lives and the society at large, this does not mean that health communications on these behaviors are no longer necessary.

3. Remaining Challenges for Sustainability. While earlier projects supported by USAID have improved awareness and changed health seeking behavior, such gains cannot be sustained unless appropriate national level leadership is developed and exerted; local communications capacities are strengthened; and the environment facilitates expanded participation of the private sector. The MOHP's capacity for leadership is not yet in place; it should be able to lead a coalition of stakeholders to develop a national public health education agenda, lead the coordination of resources, and negotiate with MOI for needed free air time and expanded support from the MOI/SIS IEC Center and the 65 MOI/SIS Local Information Centers to address additional public health topics. The MOI/SIS IEC Center currently focuses on family planning, although the MOI/SIS will need to agree to expand the staff and its capacity to address other public health topics prioritized on the national agenda and provide additional free airtime.

Although it is widely seen and influential, the Egyptian media are limited and state controlled, and mass media alone is insufficient. Interpersonal communications through community events and through service providers who are well trained in interpersonal communications are also necessary. The capacity of NGOs and community-based organizations to design and implement such communications programs continues to be weak. The profit-driven commercial sector has an essential and expanded role to play. A current network of 13,500 pharmacists and over 4,000 private physicians have been trained to provide FP counseling to their customers and patients. A mechanism to manage, increase, and improve this network; expand it to support other public health agenda concerns; and generate funds is still needed to ensure sustainability of interpersonal communications.

4. Next Steps for Sustainability.

Institutional/Technical Sustainability – A key to CHL's sustainability plan is to foster institutional growth in health, communications, planning, and implementation. It will strengthen, expand, and sustain the efforts of communications programs by improving the capacity of the MOHP to assume the leadership role in developing a national agenda for public health education, conduct strategic planning, program design, and monitoring and evaluation of communications programs. It will also work in collaboration with MOI/SIS to develop the national agenda and negotiate an annual amount of scheduled free TV and radio airtime.

The MOHP and MOI/SIS partnership will include the MOI/SIS IEC Center and 65 Local Information Centers (LICs). The IEC Center will continue to be the entity that subcontracts for the development of TV and radio spots and programs, but with an expanded focus on public

health topics (other than family planning) identified in the national agenda. The role of Egyptian commercial advertising and marketing firms will be reinforced. The MOI/SIS, which currently funds the majority of the IEC Center costs, as well as half of the development costs of TV and radio spots and programs, will need to expand its financial support to accommodate these new agenda needs. The 65 LICs, also funded by the MOI/SIS, will continue to improve and expand their local outreach, education, and communication programs with the local communities, as it moves to address additional national public health agenda issues.

CHL will help enhance the interpersonal communications of local NGOs by improving their capacity to participate in and conduct local outreach, education, and communication activities with local communities that advance positive health behavior change. CHL will coordinate with TAHSEEN to strengthen and expand the pharmacist and physician Ask-Consult network and enable it to potentially promote other health behaviors identified by the national public health agenda. CHL will have a major component of institution strengthening and training that will increase the ability of Egyptian institutions to carry out communications and behavior change interventions.

Financial Sustainability – The MOI/SIS already provides a substantial amount of free TV and radio airtime to support family planning; this is expected to continue. The MOHP and MOI/SIS will need to develop a partnership in which a reliable annual scheduled amount of free TV and radio broadcast time, likely more than is currently provided, can be negotiated that will support not only family planning, but also the broader national public health education agenda.

The MOI/SIS also supports most operating expenditures of the IEC Center and the 65 LICs salaries, and half the cost of developing TV and radio spots and programs focused primarily on family planning. The MOI/SIS will need to commit to not only maintaining these costs, but increasing its budget sufficiently to meet all costs associated with the family planning promotion, and to enable it to address other public health education issues on the national agenda.

Demand Sustainability – CHL's primary objective is to build and sustain public demand for quality health information and services, and to create a MOHP-led mechanism to sustain the demand after USAID assistance ends. This includes demand from women and men in general, but especially among special groups including youth of both genders, women of low parity, engaged couples, newlyweds, pregnant and postpartum women, and rural and urban slum residents. CHL will also assist NGOs active in the health sector to link up with non-health NGO programs - girls' education, women's literacy, and micro-credit – to help empower women to make informed decisions about FP/RH/MCH, and to further enhance demand sustainability.

E. Health Workforce Development

1. Problem Statement. The quality and quantity of medical and nursing school graduates have affected the overall quality of the health sector. Egypt's 17 medical schools (14 public and 3 private) graduate approximately 8,000 physicians each year, most of whom are

guaranteed a job in the MOHP even though they lack the required skills to function as primary heath care and family planning providers. The 11 nursing schools, on the other hand, produce too few nurses, leaving the MOHP understaffed. Additionally, most are not sufficiently trained to provide adequate nursing care. The MOHP has no legally mandated role to negotiate with the Ministry of Higher Education (MOHE) in justifying the number of medical and nursing students accepted each year even though it is the largest consumer of physician and nurse graduates.

The teaching methodology and curricula in Egyptian medical and nursing schools are not standardized and are neither competency-based nor problem-oriented. One major reason for this is that professors are not trained in teaching methodologies, and lack experience with competency-based training curricula. Effective monitoring and evaluation systems are not in place to assess the training process and to evaluate the students' analytical, problem-solving, and diagnostic skills. Furthermore, students are not sufficiently exposed to clinical skills training.

2. Sustainability Results to Date. While USAID has widely supported the in-service and some pre-service training of health personnel through various projects, this is the first time that a single cross-cutting project, the HWD, will be the locus of key selected pre-service clinical training for medical and nursing students. It will focus on essential obstetric care, family planning/reproductive health, neonatal and selected pediatric care, and community health care.

Institutional/Technical Sustainability - Within the past four years, a number of USAID-supported initiatives have strengthened undergraduate training in FP/RH and MCH. National family planning standards of practice, protocols, and uniform FP/RH curricula, developed by the MOHP with assistance from the POPULATION IV Project, are now being used by all 14 medical schools. A House Officer training course in FP/RH and MCH has introduced practical, hands-on training to complement the didactic undergraduate education in the 14 public medical schools.

In addition, the POPULATION IV Project developed the Regional Center for Training (RCT) as a regional training institute for clinical skills. Training management skills, including MIS and training logistics, have also been strengthened under this Project.

The HM/HC project introduced a new essential obstetric care and neonatal care standards of practice and protocols in 13 medical schools and supported curriculum revisions and competency-based training in 8 nursing schools in Upper Egypt. Both projects upgraded clinical training sites by providing training equipment, clinical modules, and materials. The CEED Project (now known as IDSR) developed the MOHP's capacity to train epidemiologists in tracking and responding to infectious disease outbreaks. A cadre of 36 well-trained professional epidemiologists, trained under earlier USAID projects, is already in place.

Private sector training skills were improved under the POPULATION IV Project through a subcontract with MEDTEC, a local private pharmaceutical training and detailing firm, to provide continuing medical education on contraceptive technology to a network of 13,500

pharmacists and over 4,000 private physicians. Work is underway to ensure the sustainability of this network.

Financial Sustainability – The cost of in-service training has been borne primarily by USAID, although the MOHP has contributed significantly in terms of staff salary, infrastructure, operating expenses, and more. The cost of newly developed pre-service training (curriculum development) was supported by the 14 medical and 11 nursing schools with staff salaries, infrastructure, operating expenses, and more, though USAID supported most of the technical assistance costs to date.

Demand Sustainability – The demand for this improved training among medical and nursing students will increase over time as the need and value of such training becomes increasingly apparent.

3. Remaining Challenges for Sustainability. The biggest challenge to sustainability is developing the systems and budgets within the medical and nursing schools to implement competency-based training for an increasing number of medical and nursing students. Another key challenge to sustainability is developing a system to continually update curriculum development skills and processes in order to remain dynamic and responsive to changing needs.

4. Next Steps for Sustainability.

Institutional/Technical Sustainability - HWD will focus on upgrading the quality of training and on the curriculum development process in 14 public medical and 11 nursing schools in the areas of family planning, essential obstetric care, neonatal, and selected pediatric care and community medicine. The HWD will form a National Curriculum Committee composed of faculty from medical and nursing schools to standardize curricula and to establish a system for monitoring and evaluation. Two core trainers from each of the medical and nursing schools will be trained. Improved training techniques and curricula that are competency-based will help ensure the MOHP receives better-qualified providers. Finally, HWD will establish partnerships between the faculties of American and Egyptian medical and nursing schools to institutionalize exposure to and exchange with the international community of health experts.

Financial Sustainability – The MOHP already provides major financial support for in-service training in the form of staff salaries, infrastructure, equipment, operating expenses, etc. However, as USAID support declines, the MOHP will have to increase its budget to eventually cover all costs. The 14 medical and 11 nursing schools already support the development of the new pre-service training for family planning and MCH. However, the medical and nursing schools will need to increase their budgets to cover all such costs before the end of SO 20. It is anticipated that as the newly graduated physicians and nurses are better prepared to provide basic health and family planning care, the in-service training costs and burden to the MOHP will be reduced.

F. Health Policy and Information (HPI)

1. Problem Statement. In comparison with other countries in the region, and with countries at a similar level of per capita income, Egypt's health status is lower than expected. GOE and other financial resources are inefficiently allocated and used, reflecting in part a state-owned, state managed, and doctor dominated approach to health care. The GOE and Egyptians spend relatively little on healthcare (about $55 per capita compared to Jordan at $140 per capita). Seventy percent of expenditures are on drugs, which is well above average. There is a complete absence of strategic human resource planning in the public sector, leading to over and under staffing, poor quality of services, and ultimately a waste of public resources. Over the next 10-15 years, the MOHP must tackle policy changes and structural and management improvements at both the central and decentralized levels. These changes must be supported by better use of information as a critical management tool. Information must be meaningful, utilized, and managed to contribute to the MOHP's strategic objectives.

2. Sustainability Results to Date. Over the past decade, the GOE/MOHP, assisted by several donors including the World Bank, the European Commission, and USAID, has made notable progress in developing a health reform model and in testing the model in the pilot governorate of Alexandria.

Institutional/Technical Sustainability - Currently momentum and capacity exist at senior levels in the MOHP to advance a reform program. USAID/Egypt's support to health reform has begun a historic shift in the financing and organization of health care services from a centralized system to a governorate-centered managed care system with contracting based on performance. With extensive USAID assistance in the pilot area, changes have been introduced including cost-recovery, computerized data management, and quality standards of care. Reform programs, including implementation of a family health service delivery model, are now underway in three governorates. Results have been promising, as rapid expansion of and access to affordable quality primary healthcare has increased significantly. The pilot project in Alexandria has shown that system prototypes have been developed, the quality of care has improved, and provider productivity has increased.

Financial Sustainability – Major new health insurance legislation has been proposed and is under review by the People's Assembly. When passed, this legislation will be a milestone in achieving long-term health reform and financial sustainability in the sector. MOHP reform efforts are also beginning to tackle budgetary and expenditure analysis and monitoring both the national and decentralized levels to improve effectiveness in how financial and human resources are allocated and used.

Demand Sustainability – The high quality care provided in the contracted health facilities has attracted many families residing in the neighborhood. Client volume has increased as a result of quality, affordable health care.

3. Remaining Challenges for Sustainability. Key sustainability challenges remain:

- The GOE's commitment to mobilize the private sector is unrealized.
- The oversupply of doctors and under supply of nurses constrains potential gains from health reform.

- Low quality, low coverage, and insufficient financing of primary health care services still exist. To achieve its goals of improved efficiency and impact of health spending, the GOE will need to make changes in the organization and financing of health service delivery. To do so, it will need to foster a more enabling environment for private sector participation and strengthen accountability toward consumers. To provide quality affordable healthcare to large numbers of people, especially the poor and the under-served, the GOE/MOHP will need to improve planning and management at the governorate, community, and district levels. To improve financing, it will need to rationalize drug use, reduce the cost of care, improve the public sector regulatory role, and foster increased public and private health insurance payments.
- Data as a management tool is under-utilized. The general fragmentation of the national information system and of information as a management tool represent major constraints - perhaps the most important ones - to policy change and institutional reforms in the health sector. The vertical information systems supported by USAID in the past have contributed to positive change, but have had less impact than anticipated due in part to lack of training in their use as management decision making tools. The solution to problems of poor performance in MIS is the extensive and meaningful involvement of managers and end-users in the engaging functionality and maintenance of MIS. Proper involvement of managers in the management of MIS requires the development of procedures that encourage active participation of managerial end users in planning and controlling the business uses of MIS. MIS presents managers with a major managerial challenge. Managing the information system resources of a business is no longer the sole province of information system specialist; it has become the responsibility of all managers. The challenge will be to build capacity at the district, governorate, and central levels in managing information to achieve health goals. Another major challenge of MIS is to develop information systems that promote strategic improvements in how an organization supports its people, tasks, technology, culture, and structure.

4. Next Steps for Sustainability.

Institutional/Technical Sustainability – HPI will support the GOE in implementing the Family Health Model in one governorate, covering around 10 million people. It will strengthen national health systems including information, accreditation, and regulation. In addition, it will develop technology policies and design an information technology architecture[2] that integrates the databases, applications, and the internet connected computer systems of the MOHP. This is achieved by defining and designing organizational structures, defining responsibilities and accountability of different staff levels, establishing executive direction and commitment, and defining executive roles.

Financial Sustainability – HPI activities will support the GOE in achieving financial sustainability through household and community empowerment to make informed healthcare

[2] IT Architecture, created by the strategic planning process is a conceptual design, or blueprint that includes the following major components: Technology Platform; Data resources; Application Portfolio; IT organization; Tactical IS planning.

decisions regarding the cost-sharing and utilization of more cost-effective integrated services. Information system controls will be executed to provide security and quality assurance for information systems. Examples of controls are facility controls include: facility controls such as physical protection controls, telecommunications controls, computer failure controls, and insurance. Procedural controls will include standards, procedures, documentation, authorization requirement, and auditing.

A primary task is to develop a public health insurance fund partially financed through limited increases in earmarked tax revenues, savings from cost effectiveness, as well as in subscribers and premiums paid into the fund. The challenge is to make the fund solvent and effective as a major payer and regulator of care. If properly structured, a national health insurance fund is the single most viable approach available to strengthen these key financing mechanisms, thereby improving prospects for long-term financial sustainability of the national health system. USAID, along with donor partners, will encourage and support major policy and legislative changes needed to put in place such a national health insurance fund.

IV. Sustaining Benefits: Actions for Legacy Planning

Over the years, USAID has created a range of approaches and institutions to sustain the benefits of USAID assistance. These require various levels of USAID involvement and different demands on financial resources. The Mission, with the GOE, will determine the nature of the post-assistance relationship and decide on the approaches and institutions. The Mission will refer to USAID's "Strategies for Sustainable Development" for guidance, which observes that "development is sustainable when it enhances the capacity of society to improve the quality of its life (and) enlarges the range of freedom and opportunity, not only day to day, but generation to generation."

A. Actions

The SO 20 team will consider how and to what extent it can affect the opportunities and the quality of life for future generations. It will research the legality and feasibility to provide in-kind or local currency legacy instruments to CSI/EFPA or other key institutions. With other Mission staff, consultants, and Agency documentation as guidance, it will research various legacy mechanisms in detail, develop a specific proposal for Mission review and approval, and begin building the legacy as early as possible in the transition period.

B. Approaches

Approaches that SO 20 is considering and will research include the following:

1. Bridge Funds: The purpose of this funding is to bridge a financial gap until host country institutions, or the government, are able to fund the activities possibly through assistance from another donor, or more likely through their own revenues. The positives are that bridge funds are a way for USAID to continue the benefits of promising host country institutions. But skeptics suggest that using bridge funds only delays the day when such institutions can stand on their own, and should be used sparingly - only when an institution's

track record suggests that it has a long-term future. Bridge funds could come in the form of field support to central mechanisms, or core funded central support activities.

2. Endowments: The SO 20 Team is currently considering approaches to ensure ongoing financial benefits for several activities, including the Regional Center for Training (RCT) and the Clinical Services Improvement (CSI) project. This approach may take the form of a traditional endowment, or more likely it may involve capitalizing RCT and CSI assets to help ensure a solid financial future for these organizations. Briefly, the capitalization of assets approach would involve USAID requirements that CSI and RCT:

- Develop business plans for 2002-2005, identifying projected costs and sources of revenue.
- Resolve their legal status and administrative structure.
- Reach agreement with USAID on procedures governing the use of generated revenues.
- Reach agreement with USAID on using the accumulated reserves to acquire assets to cover needed expenses (e.g., office space, a building) and/or produce tax-free revenue (rent office space to NGOs). These steps are outlined in greater detail in **Annex B.**

One advantage of the capitalization of assets approach, as opposed to a traditional endowment, is that USAID is able to leave each institution with a concrete and needed benefit, but does not need to be involved in the management, audit, or monitoring of the asset. Another possible advantage, depending on the financial analysis, is that the capitalization of assets could leave the local institution in a financially more secure situation, while costing less in USAID funds.

Other endowment possibilities to local groups include, a NGO commodities revolving fund, a DHS endowment, or an NGO doing significant public education on the issue of female genital cutting (FGC), maternal and child health, or HIV/AIDS.

3. Binational Foundation: Binational foundations imply a strong sense of ownership which bodes well for sustainability. The Mission is considering the establishment of a Foundation to support NGOs involved in multiple development areas, such as health, population, education, and environment, as well as to facilitate technical exchanges and cooperation between the US and Egypt. If the Mission decides to pursue this option, SO 20 will want to participate as well.

V. Resource Requirements and Financial Management Plan

SO 20 will need a total amount of $186,650,000 over the transition period. Investments will decline gradually every year with a much higher proportion in the first phase than in the second. Phase I (2002- 2006) will require about 87% of the total budget, the last three years of the transition period (2007-2009) will require the remaining 13%. Obligations will end in 2008, while program activities will end in 2009.

VI. Management Plan

A. Mission Staffing and Funding

The SO 20 Team Leader provides overall supervision of the projects under this Transition Plan. Two other USDH PH officers, eight FSN health professionals, one TAACS advisor and two US PSCs, three administrative staff members, and four support level staff from the Population and Health Office are managing the portfolio. In addition, other Mission units provide four support team members. The allocated staff should be sufficient to manage the proposed work at the outset, but as Mission staffing levels decline during phase-out, it will be critical that sufficient staff be applied at each stage of this transition process.

Phase I (2002-2006) Management burden does not decline during Phase I, and consequently, total SO 20 staffing levels remain constant after the precipitous drop from seven USDHs in 1999 to three in 2000.

Phase II (2007-2009) Staffing will decline sharply during this phase, in tandem with funding and the number of activities. The termination of one major project, Healthy Mother/Healthy Child, in early 2005 and major portions of other projects (e.g., NPC by 2005, RCT by 2006, contraceptives by 2006) will allow for consolidation of the number and scope of PH activities.

Phase III (2010–2011) will see the final phase-out of all SO 20 activities and completion of the Transition Plan. A skeleton staff will remain to phase-out and complete the final review of SO 20, and assist the start-up of the legacy activities.

B. GOE and other Partner Roles and Responsibilities

The Ministry of Foreign Affairs, Department of International Cooperation is the official signatory for the Government of Egypt, and will sign an SO Agreement with USAID/Egypt after receiving concurrence from the implementing partners: the MOHP, MOI/SIS, and MOHE.

The MOHP is the primary USAID partner responsible for the SO 20 activities under four projects: TAHSEEN (Improving Out Health through Planning Our Families), Healthy Mother/Healthy Child (HM/HC), Infectious Disease Surveillance and Response (IDSR), and Health Policy and Information Project (HPI). The MOHP shares this role with the MOI/SIS for the Communications for Healthy Living (CHL) Project, and it shares this role with the Ministry of Higher Education (MOHE) for the Health Workforce Development (HWD) Project.

MOHP leadership and technical staff participated in the development of program strategy, design, and implementation procedures for each of the six sub-projects and the overall SO 20 Project via numerous discussions with USAID and consultants. MOHP leadership involved in this process includes the Minister of Health, his advisors, and the Under Secretaries for Family Planning, Maternal and Child Health, Infectious Diseases and Health Reform. Many other units of the MOHP at the governorate, district, and clinic levels; selected NGOs; and commercial interests such as pharmacists and private physicians are critical USAID partners for implementation. The Ministry of Information (MOI) and its State Information Service (SIS) and the MOHE also participated in the project design discussions and decisions.

The MOHP, MOHE, and the MOI will provide counterpart staff, budget support, supplies, equipment and infrastructure, and other support such as contraceptive commodities, and free or reduced cost TV and radio airtime for the implementation of the SO 20 projects.

C. Donor Coordination

All aspects of SO 20 rely on close collaboration with other donors, including UNICEF, UNFPA, WHO, the World Bank, European Union, and others at the planning and all implementation stages. This will continue to occur through on-going formal donor coordination meetings and additional meetings and consultations as needed.

D. Cooperating Agency Coordination

The MOHP is the primary USAID partner responsible for all SO 20 activities under the six projects: TAHSEEN, IDSR, HWD, CHL, HPI, and HM/HC Project. MOHP leadership and technical staff participates with USAID and consultants in the development of program strategy, design, and implementation procedures for each of the six projects and the overall strategic objective. The MOHE is the main implementing agency for the Health Workforce Development project. The MOHE, primarily through the Supreme Council on Higher Education, is responsible for the education and training of physicians and nurses through the 18 medical and 11 nursing schools. The Supreme Council, MOHE leadership and staff, and representatives of several medical/nursing schools will be key in the implementation of the HWD Project. The MOI/SIS allocates resources for SO 20 activities, and is a signatory to all relevant obligation and planning documents. The SO 20 Team coordinates and liaises with all three ministries to ensure progress toward meeting health priorities.

E. Monitoring Transition and Sustainability

The indicators in the Performance Monitoring Plan (PMP) for SO 20 AAD were reorganized by the three types of sustainability: Institutional/Technical, Demand and Financial. Additional indicators, particularly for Financial Sustainability, have been added. See **Annex C**.

Annex A. Timeline of Key Transition Activities

Project	Phase I (FY 02-06)	Phase II (FY 07-09)
HM/HC	- Funding obligations end by FY 04. - Program activities cease by FY 05. - All systems and standards/ protocols in place by end of 2005, to be picked up by MOHP. - Technical assistance provided for hospital cost recovery. - Training curricula and lead trainers in place for continuation of in-service training by MOHP. - Technical assistance for institutionalization of community mobilization and decentralized management/ planning capacity in local elected bodies at all levels in Upper Egypt. - Technical assistance to Curative Care. - Department of MOHP to facilitate sustainability of supervision and other implementation activities. - IMCI program in place throughout nation. - Maternal and neonatal care program in place in all of Upper Egypt.	
TAHSEEN	- Contraceptive commodity support ends by 2006 (injectables in '04 and IUDs in '06). - Technical assistance through buy-in from global project - Training/human capacity development to continue into Phase II. - Explore legacy instruments for CSI/EFPA in FY 2003. Implement by 2004. - Support to CSI to end in 2006. - Grant support to other NGOs for advocacy/ outreach to continue into Phase II. - New incentives/bonus system for MOHP staff in place. - Support to commercial sector to	- In-service training ends in FY 2007. - Advocacy/outreach by NGOs to end in FY 2008. - DHS/SPA surveys and audits to continue through Phase II. - Contraceptive independence achieved by 2007. - Evaluations, research to end by 2007.

Project	Phase I (FY 02-06)	Phase II (FY 07-09)
	end in this phase. - Selected policy barriers removed.	
IDSR	- Phase I focusing on service/training activities. - Implementation Letters with MOHP, PASAs with NAMRU and CDC to continue through FY 2005. - Develop the MOHP capacity to train epidemiologists and to establish Epidemiology Surveillance Units at district and governorate levels.	- Focus on technical assistance and monitoring, evaluation and audits. - All Epidemiology Surveillance Units established. Capacity of MOHP to conduct surveillance in place. - MOHP to assume full responsibility to finance and manage Epidemiology and Surveillance Units throughout the nation. - Ministry's capacity to train new epidemiologists in place.
HWD	- Training curricula to be developed by 2004. - Partnerships with American institutions established by 2006. - 14 medical and 11 nursing schools to utilize newly developed curricula by 2006.	- New student assessment system in place. - Health education facility accreditation system in place.
CHL	- Implementation Letters with MOHP and SIS/MOI. - Technical assistance through a buy-in from global project. - Capacity of MOHP and MOI/SIS to conduct strategic planning, program design, and monitoring and evaluation of communications programs established.	- Funding support to MOHP and MOI to end by 2007. - Evaluation and audits conducted through 2009.
HPI	- Technical assistance through a buy-in from a global project and other US firms through 2006. - Implementation Letter with MOHP for the Technical Support Office.	- Support to MOHP for the Technical Support Office continues through 2008. - Health sector reform activities fine-tuned and in place in multiple governorates. - Increased efficiency of primary health care service provision. - Improved quality of integrated primary health care. - Rationalized personnel structure in health facilities. - Expanded participation of accredited NGO and private

Project	Phase I (FY 02-06)	Phase II (FY 07-09)
		health facilities through contracts.

Annex B: Next Steps for CSI/EFPA and RCT Sustainability

I. CSI/EFPA

1. Review joint USAID and IPPF assessment of EFPA and discuss next steps.

2. Reach agreement with the EFPA, IPPF and MOHP on future legal status and administrative structure for CSI and EFPA (Jan-May 2002).

3. Formalize plans: USAID and CSI/EFPA agree on purpose and procedures governing "generated" revenues and formalize plan in an IL signed by CSI/EFPA, MOHP, and USAID.

4. Require CSI to develop business plans for 2002-2004 with projected costs and sources of revenue. The business plans should elaborate steps to be taken to ensure financial and program feasibility for the planning period. Benchmarks for financial sustainability established.

5. CSI and EFPA present formal plans for reorganization and administrative structure to the EFPA Board for approval (June 2002).

6. USAID and CSI/EFPA negotiate workplan and ILs for FY 2002 which reflect the new administrative structures and arrangements (July – September 2002).

7. CSI/EFPA execute business plan to achieve financial benchmarks and CSI no longer supported by SO 20 by 2006.

8. Pursue agreements and documentation necessary to "endow" CSI/EFPA with accumulated reserves from generated revenues, and additional local currency sufficient to acquire assets which cover necessary expenses, e.g., acquire office space and/or produce tax-free revenue (rent office space to other organizations).

II. RCT

Require RCT to develop business plans for 2002-2004 with projected costs and sources of revenue. The business plans should elaborate steps to be taken to ensure financial and program feasibility for the planning period. Benchmarks for financial sustainability established.

USAID and RCT to formalize plans, agreeing on the purpose and procedures governing "generated" revenues and formalize plan in an IL signed by RCT, MOHP, and USAID.

RCT to present a formal proposal to Ain Shams University Board and the Supreme Council of Higher Education to establish its status as an autonomous administrative body affiliated with the university (faculty of Ain Shams under its tutelage [by June 2002]).

USAID and RCT negotiate the IL for FY 2002, which reorganizes the new administrative structure and states explicitly that this is the last IL planned by USAID.

RCT operates as a viable competitive concern without dedicated USAID support by 2006.

Mission builds upon GOE willingness to establish a Foundation dedicated to support of NGOs for health, population, and social interventions and advocacy, as USAID assistance declines and eventually terminates.

Annex C. Performance Monitoring Plan for Sustainability: 2002-2009

Most of the indicators in the Performance Monitoring Plan (PMP) for the SO 20 AAD can be categorized as an indicator of institutional, technical, financial, or demand sustainability. Most of the indicators listed below are from the PMP. Additional indicators are included, especially for financial sustainability.

A. Institutional/Technical Sustainability Indicators

1. Percentage of MOHP clinics with no stockouts of IUD or injectables in the past year.*
2. Percentage of FP clients who report that an FP provider provided key information according to established standards.*
3. Number of districts implementing integrated management of childhood illness (IMCI) program.*
4. Number of districts reporting on the incidence of "reportable prioritized diseases" up to the central level.*
5. Percentage of Governorate Common Laboratories (GCL) that pass standardized assessments of microbiology capacity.*
6. Annual national public health education agenda developed and implemented under leadership of MOHP with MOI/SIS.
7. Number of medical and nursing schools that have adopted competency-based curricula in four areas: family planning, neonatal care, selected pediatric care, and emergency health care.*
8. Number of families registered to receive Family Health Services.
9. Number of MOHP clinics and hospitals implementing protocols and standards of practice.

B. Financial Sustainability Indicators

1. Number of CSI clinics that achieve 90-100% financial independence.
2. GOE/MOHP finances and procures all contraceptives for the public sector.
3. Unit sales in pharmacies for injectables and orals.
4. RCT achieves financial independence.
5. GOE continues to provide/pay for free TV and radio air time for its annual national public health education agenda.
6. GOE/MOHP finances all OE for implementation of IMCI, antenatal, safe birthing and postnatal care programs.
7. Number of public and private facilities accredited and contracted with the Family Health Fund (FHF).*
8. Percentage of MOHP hospitals operating under ministerial decree guiding cost recovery.*
9. Public health insurance fund generates sufficient revenue to finance quality care for subscribers.

C. Demand Sustainability

1. Percentage of currently married women using modern contraceptive methods.*
2. Percentage of low parity, currently married women of reproductive age using FP.*
3. Percentage of births that are spaced more than 35 months.*
4. Percentage of births attended by medical providers.*
5. Percentage of women who do not support FGC.*
6. Average number of monthly visits per clinic to Comprehensive Smoking Control Centers that meet established MOHP guidelines.*

* Indicators already included in PMP.